



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Anesthesia Alliance of Dallas

Respondent Name

Texas Mutual

MFDR Tracking Number

M4-14-0846-01

Carrier's Austin Representative

Box Number 54

MFDR Date Received

November 15, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The code was billed with Modifier 59 which indicates a separate billable procedure and is to be reimbursed separate from other codes billed on the same day."

Amount in Dispute: \$209.68

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "declined to issue payment of code 99195-59 because the documentation does not establish the requestor provided some kind of blood withdrawal apart from the surgical anesthesia services."

Response Submitted by: Texas Mutual

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2013	99195 – 59	\$209.68	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 225 – The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.
 - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
 - 193 – Original payment decision is being maintained.

Issues

1. Did the requestor support the disputed services are separately payable?
2. Is the requestor entitled to reimbursement?

Findings

1. The carrier denied the disputed services as, 225 – “The submitted documentation does not support the service being billed. We will re-evaluate this upon receipt of clarifying information.” 28 Texas Labor Code §134.203(b) “For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.” Review of the submitted documentation finds use of the -59 modifier, “Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.” However, review of the submitted medical records finds no notes to support a separate and distinct service. The carrier's denial is supported.
2. Requirements of 28 Texas Administrative Code §134.203(b) were not met. No additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	September , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.